FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020255

Facility Name: Piatt County Nursing Home

Address: 1111 N. State Street (Number) Monticello (City) 61856 (Zip Code)

County: Piatt

Telephone Number: 217-762-6305 **Fax #** 217-762-6325

IDPA ID Number: 37-6001816001

Date of Initial License for Current Owners: 12/01/73

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Emily Check **Telephone Number:** 217-762-6305

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/01 to 11/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Karla Bradley

(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	166	448		614	8
9	SNF/PED					9
10	ICF	19,978	15,006		34,984	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,144	15,454		35,598	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.53%

D. How many bed-hold days during this year were paid by Public Aid?
117 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Senior Citizen Meals, meals to patients @ Kirby Hosptial

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location
Date started 12/01/73

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: _____

* All facilities other than governmental must report on the accrual basi

Facility Name & ID Number Piatt County Nursing Home # 0020255 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	333,086	26,959	17,930	377,975	1,528	379,503	(82,490)	297,013			1
2	Food Purchase		203,335		203,335		203,335	(38,084)	165,251			2
3	Housekeeping	90,891	16,056	561	107,508	1	107,509		107,509			3
4	Laundry	26,708	12,747	47,936	87,391		87,391		87,391			4
5	Heat and Other Utilities			99,571	99,571		99,571		99,571			5
6	Maintenance	121,914	17,618	19,650	159,182	655	159,837		159,837			6
7	Other (specify):*	6,959	1,233		8,192		8,192	(24)	8,168			7
8	**TOTAL General Services**	579,558	277,948	185,648	1,043,154	2,184	1,045,338	(120,598)	924,740			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,675,023	172,441	306,299	2,153,763	8,172	2,161,935		2,161,935			10
10a	Therapy		365	35,570	35,935		35,935		35,935			10a
11	Activities	101,367	2,522	1,486	105,375	346	105,721		105,721			11
12	Social Services	36,430	690	2,175	39,295	921	40,216		40,216			12
13	Nurse Aide Training	4,807	50	1,938	6,795		6,795		6,795			13
14	Program Transportation			2,450	2,450	(1,378)	1,072		1,072			14
15	Other (specify):*	15,097	836	74	16,007	215	16,222	(609)	15,613			15
16	**TOTAL Health Care and Programs**	1,832,724	176,904	351,192	2,360,820	8,276	2,369,096	(609)	2,368,487			16
	C. General Administration											
17	Administrative	54,017			54,017		54,017		54,017			17
18	Directors Fees							3,935	3,935			18
19	Professional Services			6,877	6,877		6,877		6,877			19
20	Dues, Fees, Subscriptions & Promotion			14,196	14,196		14,196	(1,232)	12,964			20
21	Clerical & General Office Expenses	148,479	14,000	34,027	196,506	(12,075)	184,431	(27,199)	157,232			21
22	Employee Benefits & Payroll Taxes			541,661	541,661		541,661		541,661			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,110	4,110		4,110		4,110			24
25	Other Admin. Staff Transportation			1,158	1,158		1,158		1,158			25
26	Insurance-Prop.Liab.Malpractice			14,649	14,649		14,649		14,649			26
27	Other (specify):*											27
28	**TOTAL General Administration**	202,496	14,000	616,678	833,174	(12,075)	821,099	(24,496)	796,603			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,614,778	468,852	1,153,518	4,237,148	(1,615)	4,235,533	(145,703)	4,089,830			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Piatt County Nursing Home #0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			179,206	179,206		179,206		179,206			30
31	Amortization of Pre-Op. & Org											31
32	Interest							(1,554)	(1,554)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			3,480	3,480		3,480		3,480			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			182,686	182,686		182,686	(1,554)	181,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,378	1,378		1,378			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify):* PCSS, FIA, Baer	48,829	1,046	22,590	72,465	237	72,702	72,702	145,404			43
44	**TOTAL Special Cost Centers**	48,829	1,046	77,340	127,215	1,615	128,830	72,702	201,532			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,663,607	469,898	1,413,544	4,547,049		4,547,049	(74,555)	4,472,494			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(440)	2		2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(116,521)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient	(24)	7		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Incom	(1,554)	32		10
11	Discounts, Allowances, Rebates & Refund	(288)	2		11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax				13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees	(901)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(103,835)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (223,563)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatio Costs (Schedule VII)	3,394		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,394		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (220,169)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport	X		$ 1,378	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,378		47

Piatt County Nursing Home

ID# 0020255

Report Period Beginning: 12/01/01

Ending: 11/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Patient Meals	$ 116,521	1	1
2	Diet Supplies - Kirby	(3,325)	1	2
3	Volunteers - Courtesy Cart	(609)	15	3
4	Operating Income - Foundation Reimburse	(27,169)	21	4
5	Jury Duty Recovery	(30)	21	5
6	PCSS, FIA, Baer	(72,702)		6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	12,686		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Piatt County Nursing Home # 0020255 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	113,196	0	0	0	0	0	0	0	0	0	0	113,196	1
2	Food Purchase	(117,249)	0	0	0	0	0	0	0	0	0	0	(117,249)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(24)	0	0	0	0	0	0	0	0	0	0	(24)	7
8	**TOTAL General Services**	(4,077)	0	0	0	0	0	0	0	0	0	0	(4,077)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(609)	0	0	0	0	0	0	0	0	0	0	(609)	15
16	**TOTAL Health Care and Programs**	(609)	0	0	0	0	0	0	0	0	0	0	(609)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	2,788	0	0	0	0	0	0	0	0	0	2,788	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(901)	0	0	0	0	0	0	0	0	0	0	(901)	20
21	Clerical & General Office Expenses	(27,199)	606	0	0	0	0	0	0	0	0	0	(26,593)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,100)	3,394	0	0	0	0	0	0	0	0	0	(24,706)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,786)	3,394	0	0	0	0	0	0	0	0	0	(29,392)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Piatt County Nursing Home # 0020255 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,554)	0	0	0	0	0	0	0	0	0	0	(1,554)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,554)	0	0	0	0	0	0	0	0	0	0	(1,554)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,340)	3,394	0	0	0	0	0	0	0	0	0	(30,946)	45

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Nursing Home Comm Mtg	$		100.00%	$ 2,788	$ 2,788	1
2	V	21	IMRF/FICA		County Clerk Office	100.00%	287	287	2
3	V		Health Plan Ins. Reports						3
4	V		Fed & IL Income Tax						4
5	V		Unemployment Comp Report						5
6	V	21	Reconciling Bank Statement		County Treasurer's Office	100.00%	319	319	6
7	V		Recording Checks; A/P & P/R						7
8	V		Check Signing;Funded Depr.						8
9	V								9
10	V								10
11	V								11
12	V	22	IMRF/FICA	239,505			239,505		12
13	V	22	SUTA & Health Insurance	201,642			201,642		13
14	Total			$ 441,147			$ 444,541	$ * 3,394	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE N/A

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2001 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru	$	#VALUE!	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Piatt County Nursing Home COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0020255

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,120 B. General Construction Type: Exterior Brick Frame Comb w/Sprinkler Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Site	182,952	1973	$ 35,000	1
2					2
3	TOTALS	182,952		$ 35,000	3

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1973	1970	$ 800,000	$ 26,667	30	$ 26,667	$	$ 773,343	4
5	36		1975	1974	525,102	17,504	30	17,504		488,581	5
6	4		1989	1989	863,408	28,780	30	28,780		388,531	6
7	Bldg Proj		1993	1992	244,299	8,144	30	8,144		77,363	7
8											8
	Improvement Type**										
9	Building Improvements			1976	7,130		20			7,130	9
10	Building Improvements			1977	8,236		20			8,236	10
11	Building Improvements			1978	541		20			541	11
12	Building Improvements			1979	4,254		5			4,254	12
13	Building Improvements			1980	170,832		20			170,832	13
14	Building Improvements			1981	6,276		20			6,276	14
15	Building Improvements			1982	6,960	174	20	174		6,960	15
16	Building Improvements			1983	56,871	2,844	20	2,844		55,455	16
17	Building Improvements			1984	1,490		5			1,490	17
18	Building Improvements			1984	1,831		10			1,831	18
19	Building Improvements			1984	7,260	363	20	# 363		6,716	19
20	Building Improvements			1985	962		5			962	20
21	Building Improvements			1985	18,315	916	20	916		16,029	21
22	Building Improvements			1986	6,415		10			6,415	22
23	Building Improvements			1986	5,472	274	20	274		4,520	23
24	Building Improvements			1987	7,987		5			7,987	24
25	Building Improvements			1987	3,597		10			3,597	25
26	Building Improvements			1987	1,000	30	15	30		1,000	26
27	Building Improvements			1987	1,509	75	20	75		1,164	27
28	Building Improvements			1988	5,395		5			5,395	28
29	Building Improvements			1988	22,150	1,477	15	1,477		21,415	29
30	Building Improvements			1988	22,737	1,137	20	1,137		16,486	30
31	Building Improvements			1989	72,494	4,833	15	4,833		65,245	31
32	Building Improvements			1989	18,169		5			18,169	32
33	Building Improvements			1990	13,836	922	15	922		11,526	33
34	Building Improvements			1991	1,120		5			1,120	34
35	Building Improvements			1991	2,890		10			2,890	35
36	Building Improvements			1991	44,194	2,946	15	2,946		33,880	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvments	1992	$ 5,532	$ 277	10	$ 277	$	$ 5,532	37
38	Building Improvments	1993	21,036	2,104	10	2,104		19,987	38
39	Building Improvments	1994	5,888	589	10	589		5,005	39
40	Building Improvments	1995	8,381	838	10	838		6,285	40
41	Bdlg Improve: Remodeled ADM Office; Remodel ARD Room	1996	7,582	758	10	758		4,928	41
42	Replace Crash Rails in 50's & 60's Hall								42
43	Bldg Improvements: New Pipes & New Roof	1997	227,748	11,388	20	11,388		62,631	43
44	Bldg Improvements: New Water Heate	1998	5,377	358	15	358		1,612	44
45	Bldg Improve: Paint Room & Halls; Water Heater Instal	1998	4,046	202	20	202		910	45
46	Bldg Improve: Security System & Heat Pumps	1999	17,009	3,402	5	3,402		11,907	46
47	Bldg Improve: Kitchen Remodeling;Halcyon Roof & Remode	1999	85,221	4,261	20	4,261		14,914	47
48	Bldg Improve:Phones & Wiring;Handicap Door;Carrier Unit	2000	13,585	1,359	10	1,359		4,076	48
49	Bldg Improve:Patient Overbed Lights; Dining Room Remode	2000	23,373	1,558	15	1,558		4,674	49
50	Bldg Improve:Resident Room & Common Areas Remodeling	2001	46,868	4,687	10	4,687		9,374	50
51	Bldg Improve: Carrier Units	2001	3,080	205	15	205		410	51
52	Bldg Improve: Garage Roof & Feasibility Study	2002	4,588	229	10	229		229	52
53	Bldg Improve: Overbed Lights, Closet Doors; Convectors	2002	21,597	720	15	720		720	53
54	Bldg Improve: Tile work in shower room	2002	2,267	57	20	57		57	54
55	Grounds Improvements	1976	954					954	55
56	Grounds Improvements	1977	2,298		10			2,298	56
57	Grounds Improvements	1978	1,729		10			1,729	57
58	Grounds Improvements	1979	6,235		10			6,235	58
59	Grounds Improvements	1980	3,031		10			3,031	59
60	Grounds Improvements	1981	2,803		10			2,803	60
61	Grounds Improvements	1982	1,196		10			1,196	61
62	Grounds Improvements	1983	1,212		12			1,212	62
63	Grounds Improvements	1984	7,796		10			7,796	63
64	Grounds Improvements	1986	1,077		10			1,077	64
65	Grounds Improvements	1987	6,713		3			6,713	65
66	Grounds Improvements	1987	1,118		10			1,118	66
67	Grounds Improvements	1989	11,701		10			11,701	67
68	Grounds Improvements	1990	2,682		10			2,682	68
69	Grounds Improvements	1992	51,409	2,570	10	2,570		51,409	69
70	TOTAL (lines 4 thru 69)		$ 3,557,864	$ 132,648		$ 132,648	$	$ 2,470,544	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forwarc		$ 3,557,864	$ 132,648		$ 132,648	$	$ 2,470,544	1
2	Grounds Improvements	1993	4,988	499	10	499		4,739	2
3	Grounds Improve: New Signs front/rear entrance;restripe lc	1996	9,884	988	10	988		6,423	3
4	Grounds Improve: Tree removal & excavatio	1998	8,691						4
5	Grounds Improve:ARD Awning;Truck turnaround; sidewalk rai	1998	6,461	646	10	646		2,907	5
6	Grounds Imrpove: Tile Repair	1999	765	77	10	77		268	6
7	Grounds Improve: Conrete Patic	2000	2,107	211	10	211		632	7
8	Grounds Improve: Landscaping	2001	1,850	370	5	370		740	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,592,610	$ 135,439		$ 135,439	$	$ 2,486,253	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe Piatt County Nursing Hom # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 412,051	$ 40,773	$ 40,773	$		$ 211,321	71
72	Current Year Purchases	39,640	1,870	1,870			1,870	72
73	Fully Depreciated Assets	354,945	774	774			354,945	73
74								74
75	TOTALS	$ 806,636	$ 43,417	$ 43,417	$		$ 568,136	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van - transportation	Dodge 1987	1987	$ 22,745	$	$	$		$ 22,745	76
77	Wheelchair Lift	Braun L400 1996	1996	3,495	350	350		10	2,275	77
78										78
79										79
80	TOTALS			$ 26,240	$ 350	$ 350	$		$ 25,020	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,460,486	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,206	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 179,206	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,079,409	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1975	Storage Rent		$ 3,480	N/A	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL				$ 3,480 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,267	$	$ 1,267
2	Books and Supplies		50		50
3	Classroom Wages (a)		3,221		3,221
4	Clinical Wages (b)		1,586		1,586
5	In-House Trainer Wages (c)				
6	Transportation		441		441
7	Contractual Payments				
8	Nurse Aide Competency Tests		230		230
9	TOTALS	$	$ 6,795	$	$ 6,795
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,795			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit
(b) Include wages paid during the clinical portion of training. Do not include fringe benefit
(c) For in-house training programs only. Do not include fringe benefit
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	728	$ 11,785	$	728	$ 11,785	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		81	5,775		81	5,775	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		1,236	18,010		1,236	18,010	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10,2	# of prescrpts				9,588		9,588	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	2,045	$ 35,570	$ 9,588	2,045	$ 45,158	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 61,825	$ 265,610	1
2	Cash-Patient Deposits		5,018	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	386,175	628,470	3
4	Supply Inventory (priced at LCM)	40,580	40,580	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,355	7,355	6
7	Other Prepaid Expenses	2,088	2,088	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 498,023	$ 949,121	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000	35,000	13
14	Buildings, at Historical Cost	3,617,396	3,617,396	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	832,876	832,876	16
17	Accumulated Depreciation (book methods)	(3,079,407)	(3,079,407)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,405,865	$ 1,405,865	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,903,888	$ 2,354,986	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 111,659	$ 111,911	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		5,018	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,050	56,050	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits	247,293	247,293	36
37	Interfund Payable	242,295	242,295	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 657,297	$ 662,567	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 657,297	$ 662,567	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,246,591	$ 1,692,419	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,903,888	$ 2,354,986	48

***(See instructions.)**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,463,745	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,463,745	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(217,154)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (217,154)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,246,591	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 3,606,030	1
2	Discounts and Allowances for all Level	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,606,030	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	440	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 440	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	4,476	11
12	Gift and Coffee Shop	609	12
13	Barber and Beauty Care	2,108	13
14	Non-Patient Meals	69,078	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient	3,349	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 79,620	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	1,554	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,554	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule	641,609	28
28a	Interfund Transfers	642	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 642,251	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,329,895	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,043,154	31
32	Health Care	2,360,820	32
33	General Administration	833,174	33
	B. Capital Expense		
34	Ownership	182,686	34
	C. Ancillary Expense		
35	Special Cost Centers	127,215	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,547,049	40
41	**Income before Income Taxes (line 30 minus line 40)****	(217,154)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (217,154)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,311	1,663	$ 39,169	$ 23.55	1
2	Assistant Director of Nursing	1,703	2,090	42,350	20.26	2
3	Registered Nurses	17,168	18,649	389,567	20.89	3
4	Licensed Practical Nurses	12,157	13,996	228,561	16.33	4
5	Nurse Aides & Orderlies	82,011	90,774	937,793	10.33	5
6	Nurse Aide Trainees		621	4,807	7.74	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	303	303	4,584	15.13	9
10	Activity Assistants	9,560	10,673	96,783	9.07	10
11	Social Service Worker	2,536	3,055	36,430	11.92	11
12	Dietician					12
13	Food Service Supervisor	1,979	2,198	37,940	17.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,086	35,913	295,146	8.22	15
16	Dishwashers					16
17	Maintenance Worker	9,520	10,702	128,873	12.04	17
18	Housekeepers	9,730	10,794	90,891	8.42	18
19	Laundry	3,222	3,453	26,708	7.73	19
20	Administrator	1,881	2,105	53,889	25.60	20
21	Assistant Administrator					21
22	Other Administrative	9,158	10,702	148,657	13.89	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Restorative	466	467	11,691	25.03	32
33	Other(specify) Nsg Sec/Vol/PC	7,594	8,534	89,818	10.52	33
34	TOTAL (lines 1 - 33)	202,385	226,692	$ 2,663,657 *	$ 11.75	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	160	$ 6,620		50
51	Licensed Practical Nurses	5,646	176,123		51
52	Nurse Aides	5,801	105,529		52
53	TOTAL (lines 50 - 52)	11,607	$ 288,272		53

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karla Bradley	Executive Director		$ 54,017
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 54,017

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
May, Cocagne, & King	Audit	$ 6,588
Duane, Morris, Heckscher, LLP	Legal	289
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 6,877

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,000
Unemployment Compensation Insurance	8,851
FICA Taxes	198,989
Employee Health Insurance	221,747
Employee Meals	5,700
Illinois Municipal Retirement Fund (IMRF)*	40,516
Employee Awards Program & Assist Program	4,431
Medical Expense - Physicals	1,427
TOTAL (agree to Schedule V, line 22, col.8)	$ 541,661

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,908
Health Care Worker Background Check	
(Indicate # of checks performed 3)	30
Joint Commission Dues	2,088
LSN Dues	4,671
HCFA Lab Program	150
Illinois Rural Health	200
Subscriptions	477
Employers Assoc, ASA, County NH Assoc	440
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,964

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	797
Seminar Expense	3,313
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,110

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/01 Ending: 11/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **No**

(2) Are there any dues to nursing home associations included on the cost repor **Yes**
If YES, give association name and amount **JCAHO $2088, LSN $4671, ASA $275**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **No** If YES, have these cost
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perio

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **36,274** Line **No**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **No**
If YES, give effective date of lease

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **54,750**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee? **Yes** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **Yes**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **0** Has any meal income been offset agains
related costs? **Yes** Indicate the amount $ **15,322**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **No** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **N/A**
d. Have vehicle usage logs been maintained **Yes**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period $

(17) Has an audit been performed by an independent certified public accounting firm **Yes**
Firm Name: **May, Cocagne, & King P.C.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **Yes** If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report
Attach invoices and a summary of services for all architect and appraisal fee

Expense Reallocation Recap FY 2001 Cost Report Schedule V

	Nursing	Soc Svc	Activities	Vol	Dietary	Maint	Hskp	Admin	Nursing Transport	Employee Benefits	Faith In Action	Medical Transport	Plant Op
Transportation - Medical Purposes Resident									-1378.00			1378.00	
ADM- Clerical Exp Allocation	5205.00		161.00		535.00			-5901.00					
Telephone Expense	2694.00	754.00			754.00	646.00		-4848.00					
Copier Expense	273.00	167.00	185.00	215.00	239.00	9.00	1.00	-1326.00			237.00		
Total	8172.00	921.00	346.00	215.00	1528.00	655.00	1.00	-12075.00	-1378.00		237.00	1378.00	
Line #	10	12	11	15	1	6	3	21	14	22	43	38	6+

Piatt County Nursing Home
Income Statement Revenue
30-Nov-02

Shedule XVII, Line 28 - Other Revenue:

Jury Duty Recovery	30.00
NA Training Contractual Recovery	270.00
Purchase Rebate	288.00
Write Off Accounts Receivable	3679.00
Gain or Loss/Sale of Assets	-755.00
Foundation Contribution	27169.00
PCSS Income	52366.00
FIA Income	25700.00
Transfer from County	529518.00
Baer Property Revenue	3075.00
	641340.00

Cost Center Expenses - Supporting Schedule

Section V, Line 7 - General Services

Materials Management:

Salaries	$ 6,959.00
CS Inventory Supplies - Kirby	$ 23.00
Other Supplies	$ 1,210.00
	$ 8,192.00

Schedule V, Line 15- Health Care & Programs

Volunteer Program Coordinator:

Salaries & Wages	$15,097.00
Courtesy Cart Supplies	$ 476.00
Other Supplies	$ 360.00
Staff Development	$ 15.00
Travel	$ 59.00
	$16,007.00

Schedule V, Line 43 - Special Cost Centers

Piatt County Services for Seniors:

Salaries & Wages	$31,204.00
Telephone Expense	$ 1,736.00
Postage Expense	$ 501.00
Copier Expense	$ 328.00
Supplies	$ 551.00
Secretarial Service	$ 3,600.00
Rental Expense	$ 1,800.00
Staff Development	$ 370.00
Travel	$ 4,399.00
	$44,489.00

Piatt County Nursing Home serves as the Grant Sponsor for this agency which is chiefly supported by an Area Agency Grant. All expenses for this agency have been eliminated on Schedule V, Line 43.

Faith In Action:

Salaries & Wages	$17,625.00
Telephone Expense	$ 1,029.00
Postage	$ 959.00
Copier Expense	$ 84.00
Supplies	$ 496.00
Marketing Expense	$ 1,519.00
Volunteer Recognition	$ 405.00
Insurance Expense	$ 662.00
Rental Expense	$ 720.00
Fundraising expense	$ 15.00
Staff Development	$ 155.00
Travel	$ 552.00
Care Management Expense	$ 29.00
Care Management Travel	$ 297.00
	$24,547.00

Piatt County Nursing Home serves as the Grant Sponsor for this agency wich is chiefly supported by miscellaneous grants and donations. All expenses for this agency have been eliminated on Schedule V, Line 43.

Baer Property:

Property Tax	$ 2,554.00
Insurance	$ 545.00
Repairs	$ 34.00
	$ 3,133.00

This property expense is incurred on the Piatt County Nursing Home Foundation property. All expenses have been eliminated from Schedule V, Line 43.

Piatt County Nursing Home
Supporting Schedules
November 30, 2002

Schedule XIX, Section G - Schedule of Travel and Seminar	Seminar Expense - Staff Dev	
K. Bradley, Executive Director Demystifying Individual Rights Under HIPPA Privacy Regualtions Audio Conference	Life Services Network 11/26/2002	$52.00
K. Bradley, Executive Director Employment Protected Absences Peoria, IL	Employer's Association 11/7/2002	$147.00
K. Bradley, Executive Director LSN's Information Forum Decatur, IL	Life Services Network 10/18/2002	$20.00
K. Bradley, Executive Director HIPAA 101, A General Primer for Staff Audio Conference	Life Services Network 7/17/2002	$50.00
K. Bradley, Executive Director HIPAA, Let's Start At The Beginning Springfield, IL	Life Services Network 6/6/2002	$139.00
K. Bradley, Executive Director LSN Annual Conference, A Mission of Promise Chicago, IL	Life Services Network 4/10-4/12/02	$689.00
K. Bradley, Executive Director Abuse & Neglect Dectection & Prevention Springfield, IL	OCC 1/30/2002	$98.00
K. Bradley, Executive Director IOC Provider Training Springfield, IL	IHCA 2/20/2002	$123.00
S. Craig, Personnel Director Demystifying Individual Rights Under HIPAA Privacy Regulations Audio Conference	Life Services Network 12/13/2002	$52.00
S. Craig, Personnel Director Putting You Knowledge to Work; Practial Implementation Skills Springfield, IL	Life Services Network 10/2/2002	$99.00
S. Craig, Personnel Director HIPAA 101, A General Primer for Staff Audio Conference	Life Services Network 7/17/2002	$49.00
S. Craig, Personnel Director Healthcare: Nursing Homes In Crisis Bloomington, IL	IACBMC 6/25/2002	$45.00
S. Craig, Personnel Director LSN Annual Conference, A Mission of Promise Chicago, IL	4/10-4/12/02	$689.00
S. Craig, Personnel Director Abuse & Neglect Dectection & Prevention Springfield, IL	OCC 1/30/2002	$98.00
Sheryl Gadbury, Personnel Coordinator Time Off in Illinois Champaign, IL	Lorman Education Services 5/23/2002	$260.00
K. Glennon, Accounting Coordinator LSN Annual Conference, A Mission of Promise Chicago, IL	4/10-4/12/02	$688.00
C. Summers, Accounting Assistant Billing Training for Non-Emergency Transportation Decatur, IL	IDPH 9/17/2003	$15.00
		$3,313.00